STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295001	A. BUILDING _____ B. WING _____	10/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEFA SERAN SNF	1ST AND A ST/ PO BOX 1510 HAWTHORNE, NV 89415

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F 000	INITIAL COMMENTS Surveyor: 26252 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on October 12, 2009 through October 14, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 23 residents. The sample size was 10 sampled residents which included 1 closed record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26252 Based on record review and staff interviews, the facility failed to ensure that residents comprehensive assessments were fully and accurately completed, with correct signature sign off of the assessments for 4 of 10 residents (Residents #3, #4, #9, #10). Findings include: Resident #4 Resident #4 was admitted to the facility on 8/30/07, with diagnoses including vascular dementia with delirium, depression with anxiety, blindness, agitation, hypertension, insomnia, hip pain and post traumatic stress disorder. On 10/13/09, Resident #4's quarterly comprehensive assessment document, the	F 272		

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F 272	Continued From page 2	F 272		

Minimum Data Set (MDS) with the reference date of 5/27/09 was reviewed. The following sections of the MDS were not completed: B3. Memory/Recall Ability, G3. Test for Balance, G7. Task Segmentation, I1. Diseases, K1. Oral Problems, K6. Parenteral or Enteral Intake, M4. Other skin Problems or Lesions, M5. Skin Treatments, M6. Foot Problems and Care, O3. Injections, P1. Special Treatments, Procedure, and Programs, and P3. Nursing Rehabilitation/Restorative Care.

The signature verifying the MDS assessment was not completed for approximately one month. The signatures in Sections 9 and R2 were signed on 6/20/09.

Resident #10

Resident #10 was admitted to the facility on 11/4/08, with diagnoses including vascular dementia, diabetes mellitus, congestive heart failure, hypertension, hypothyroid, late effects of cerebrovascular accident, depression with anxiety, constipation, gastroesophageal reflux disease, and recurrent urinary tract infection.

On 10/14/09, Resident #10's quarterly MDS, with the reference date of 5/27/09, was reviewed. The signature verifying the MDS assessment was not completed for several months. The signatures in Sections 9 and R2, were signed on 8/9/09.
Surveyor: 19948

Resident #3

Resident #3 was admitted to the facility on 9/08/09 with diagnoses that included altered mental status, congestive heart failure, and

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F 272	Continued From page 3	F 272		

urosepsis. The resident had an indwelling Foley catheter to down drain.

The MDS, a Medicare 30 day assessment, completed on 10/07/09, was reviewed. Section H. (Continence, Self Control Categories), under b. Bladder Continence, documented that Resident #3 was continent. Section H3. (Appliances and Programs), did not indicate that resident had an Indwelling catheter. Observation of the resident on 10/13/09 revealed that resident had a indwelling Foley catheter.

Review of Resident #3's care plans denoted a care plan, dated 9/17/09, for the risk of developing complications of repeated infections due to having a Foley catheter. The approaches for the care plan included providing indwelling Foley catheter care.

In an interview with Employee #3, the MDS coordinator, on 10/13/09, she acknowledged that a coding error had been made by not acknowledging the presence of an indwelling Foley catheter in section H3. Appliances and Programs.

The comprehensive assessment for Resident #3 was not accurate for urinary continence.

Resident #9

Resident #9 was admitted to the facility on 11/14/08. His diagnoses included previous cerebral vascular accident, dysphagia, congestive heart failure, hypertension and type II diabetes.

A quarterly MDS, completed on 6/20/09, was reviewed. Section G. (ADL Self Performance),

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F 272	Continued From page 4 had not been completed as evidenced by the absence of ADL Support Provided codes in column B. In addition, there was no documentation in Section I1. (Diseases), K1. (Oral Problems), M4. (Other Skin Problems or Lesions Present), M5. (Skin Treatments), or M6. (Foot Problems and Care). Employee #2 had signed the assessment on 6/20/09 as being complete. An interview was conducted with Employee #2 on 10/14/09. She acknowledged that she was not aware that the MDS was not complete when she signed it. Note: It is difficult to ascertain if there has been a significant change in the resident's status if data is absent or incorrect in the previous MDS.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26252 Based on record review and staff interviews, the facility failed to address and develop a interim care plan to meet the needs of a resident which were identified upon admission for 1 of 10 residents (Resident #1). Findings include: Surveyor: 19948 Resident #1 Resident #1 was admitted most recently, to the	F 281		

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F 281	Continued From page 5	F 281		

facility on 10/05/09 following an acute care stay. Diagnoses included dementia, delirium, decubiti and hypertension. The resident had several earlier admissions to Long Term Care (LTC) with the family requesting discharge when she had stabilized.

During her acute care stay, Resident #1 had been identified by abdominal x-ray (10-3-09) as having a fecal impaction. The impaction was treated with one oral dose of Dulcolax, a laxative. Review of the nurses notes from the acute hospital did not document any bowel movements for Resident #1 from 10/3/09 to 10/05/09 when she was transferred to the LTC.

After admission to LTC, Medication Administration Records (MAR) revealed that Resident #1 was receiving Colace, a stool softener, twice a day. She was also receiving three forms of pain medications (with known side effects of constipation).

Nurses notes documented a Dulcolax suppository being given to Resident #1 on 10/6/09 during the night shift. The suppository was not recorded on the MAR as being given. There was no follow up documentation in the nurses notes as to the results or lack of results from the suppository, nor were there results noted on the bowel movement (BM) record. The MAR also revealed that on 10/11/09, Milk of Magnesia (MOM) was given to Resident #1. The MOM was not referenced in the nurses notes nor on the BM Record. There was no reference to the fecal impaction in any of the documentation.

Review of the LTC facility's BM Record for Resident #1 revealed that there was no

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F 281	Continued From page 6	F 281		

documentation of a bowel movement for the resident from admission (10/05/09) until the day shift on 10/8/09. No additional bowel movements were documented from 10/08 until the time of the chart review on 10/12/09.

The Facility's bowel protocol was Milk of Magnesia (MOM) as needed at bedtime. If no results, then a rectal suppository could be administered. If no results from the suppository, an enema could be utilized. If no results from the protocol, then the physician was to be notified. There was no evidence that the protocol was administered as ordered.

The resident had not been at the facility long enough for the 14 day comprehensive assessment to have been completed, which should have resulted in a patient specific, problem related care plan. However, the facility's Admission Data Collection Tool, which was completed for Resident #1 on 10/5/09, had the provision for an interim care plan to be developed at the end of the assessment. No interim care plan had been developed for Resident #1's known problem of constipation or her previous history of fecal impaction.

In an interview with Employee #3, the MDS Coordinator, on 10/12/09, she acknowledged that interim care plans are developed for the residents prior to the 14 day assessment. She agreed that a care plan for constipation was not present for Resident #1.